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A Look at the Impact of BBA'97 on Medicare Payments

Clinton Administration Culpable on Medicare

Much attention has been given recently to the dramatic changes in Medicare spending. And well it should be: Medicare will face in the near future the largest challenge in its history. Not only will it be caring for the largest beneficiary population in its history, it will be caring for the longest-lived population in its history, all while health care has become the most expensive in its history. The challenge is as enormous as it is undeniable.

To meet this challenge, both Congress and the Clinton/Gore Administration must move carefully and correctly as Medicare reform goes forward. But for reform to go forward, the Administration must focus on Medicare as policy — not as politics.

The policy changes made to Medicare in the bipartisan Balanced Budget Act of 1997 (BBA'97) were the largest since the program's inception, and so are a natural point for examination. Even though BBA'97 is now two years old, it is still too early to state definitively what has caused the dramatic fluctuation in Medicare spending, or to determine how long it will continue, or even its repercussions on Medicare recipients and providers. Yet, this paper explores the impact measured to date and finds some reassurance.

While definitive causes and outcomes to the recent spending trends aren't yet available, it is possible to reach some definitive conclusions about the impact of the Clinton Administration's actions on Medicare's security.

- First, the Clinton/Gore Administration's agency in charge of Medicare, the Health Care Financing Administration (HCFA), must bear some blame as a result of both its actions and its inactions.

- Second, the White House continues to pursue policies — including $19 billion in program spending reductions — that are both questionable and in fact dangerous for Medicare.

- Third, the White House has pursued its political agenda through the Medicare program, such as promising expensive new benefits while avoiding overall reform, which is particularly dangerous in light of the current and future uncertainty facing Medicare's financial picture. [See 6/30/99 RPC paper: *"This is Medicare Reform?"*]

It is imperative to remember that Medicare is a program that faced imminent bankruptcy just two short years ago. It will face bankruptcy again after 2015 without further major changes. And even this breathing spell is premised on Medicare running razor-thin surpluses over the next few years. According to the Congressional Budget Office's (CBO) 3/99 baseline, Medicare's Part A trust fund will run just a $54 billion surplus from 2000 through 2006 and then run deficits of -$5 billion in 2007, -$13 billion in 2008, and -$21 billion in 2009 — this means just a cumulative surplus of $15 billion over the next ten years.

With even slight changes in circumstances Medicare could quickly return to its precarious pre-BBA'97 fiscal condition. By the same token, any additional Medicare spending will adversely affect Medicare's trust fund balance.

Medicare Spending Has Slowed

Medicare spending has a history of volatility. What makes the current volatility so unusual is that this time the dramatic change is downward rather than upward. Rather than its normal course of rising precipitously, spending has slowed in its rate of growth, and actually in some instances has fallen. Medicare's total outlays are 1.1 percent below last year's spending level for the first 11 months of the current fiscal year, according to CBO estimates. This follows a scant 1.5-percent rate in spending growth in 1998. In contrast, Medicare spending grew approximately 9 percent per year between 1993 and 1996. Prior to BBA'97, Medicare spending was expected to continue on this unsustainable 9-percent growth rate through 2007.

As a result of Medicare's virtually uncontrolled spending growth and its trust fund's impending bankruptcy, the BBA'97 aimed to slow the rate of spending growth. When the bill was before Congress, CBO estimated that it would result in Medicare spending slowing to a 5.8-percent rate through 2002 and to 7.2 percent through 2007. CBO now estimates Medicare spending to grow 4.5 percent over five years and 6.5 percent over ten years.

Naturally, the slowdown in overall spending growth has also been witnessed in the individual parts of the Medicare program. As an example, the projected growth in home health service spending has been lowered from 8.3 percent to 5.6 percent per year.

Why Has Medicare Spending Slowed?

Medicare spending has slowed remarkably — both in comparison to historic trends and to future estimates — that is beyond dispute. What remains to be determined is the "Why?" There are several possible answers but as yet no definitive one.

While this slowdown marks a departure from Medicare's programmatic history, it is not that unusual in context to the economy as a whole where slowdowns in price increases and low inflation have become the relative norm. Inflation overall is down and has remained so for some time. It is not surprising that some of this would spill over to Medicare savings. In addition, with a robust economy workers are more likely to remain employed, and so delay their reliance on Medicare. Obviously, this leads to savings as well.

The spending reduction also has a compounding effect. If spending is slower than expected in one year, then the next year's spending has a good chance to beat initial estimates, too. Why? Because the base has been lowered from which the future estimates are made. Here's an example: take a base of 100 and estimate 10-percent growth for each of the next five years, and the result is a figure of 146.4. If 90 is the base instead of 100, then even with 10-percent growth in the intervening years, the five-year result only amounts to 131.8.

Of course, the Medicare provisions in BBA'97 were intended to slow down the rate of Medicare's spending growth. This was imperative in order to prevent Medicare's trust fund from bankrupting in 2001 (the BBA'97 changes originally were estimated to extend the trust fund to 2007). Key policy changes enacted by BBA'97 included a reduction in payment updates or slowing the growth in payments for virtually all Medicare providers in addition to comprehensive changes to how payments are made and calculated.

William Scanlon, Director of Health Financing and Public Health Issues for the General Accounting Office (GAO), stated in testimony before the House on September 15 of this year that BBA'97's payment reforms "represented bold steps to control Medicare spending by changing the financial incentives inherent in payment methods that, prior to BBA'97, did not reward providers for delivering care efficiently." And Murray Ross, Executive Director of the Medicare Payment Advisory Commission (an independent federal body that advises Congress on issues affecting Medicare, commonly referred to as "MedPAC") stated at the same House hearing that BBA'97 "enacted the most far-reaching changes to the Medicare program since its inception."

It should also be remembered that the Medicare component of BBA'97 was not simply a compilation of savings, but a compilation of policies intended to result in savings. Some of these policies may have been more effective than anticipated. Take fraud and abuse reduction efforts. Medicare has been plagued for years by improper payments due in part to fraud and abuse, and greater savings from the more careful claims screening process mandated by BBA'97 can only be seen as positive. CBO in fact estimates that hospitals' less aggressive billing practices (in reaction to closer scrutiny) alone reduced Medicare spending by 0.75 percentage points in 1998.

Claims payment slowdown is another possible explanation. With greater scrutiny and changes resulting from BBA'97, both processors and filers may be taking more care with their claims, thus resulting in an apparent reduction in overall spending growth. The practice of sequential billing, where payments are made only if all prior claims have been filed, may also have contributed to the processing, and thereby to the spending, slowdown. This practice was suspended by HCFA in July.

In some cases, there has been an unanticipated "behavioral response" whereby service providers have reacted to a greater degree than anticipated to the actual policy changes themselves. Apparently a case in point is home health service providers who have reacted more strongly to the average per-patient expense limit of BBA'97. While the law did not intend that providers limit each patient to the average rate — but instead blend high-cost patients with lower-cost ones to arrive at the average rate — some providers apparently have done so. The result is a drop in the

"case-mix" index and lesser-than-anticipated payments overall. The same "behavioral response" phenomena may exist in other areas as well.

What Does the Slowdown in Growth Mean to Beneficiaries?

Most importantly, how is the spending slowdown affecting beneficiaries? Again, it is too early to answer this question definitively, or to know the impact among Medicare's many services. Yet, clearly beneficiaries have not been adversely affected on the whole thus far.

MedPac has examined some complaints from service providers and in testimony before the House Commerce Committee's Subcommittee on Health and Environment on September 15, 1999, MedPac's executive director provided this assessment:

- Impact on hospitals: "MedPac has seen no convincing evidence that the changes to date have affected either quality or access in the inpatient sector. . ."

- Impact on home health agencies: "GAO concluded that the closures [of home health agencies across urban and rural counties] have had little impact on Medicare beneficiaries to date."

- Impact on Skilled Nursing Facilities (SNFs): "The Office of the Inspector General (OIG) of the Department of Health and Human Services . . . surveyed a random sample of 200 hospital discharge planners responsible for arranging nursing home care for patients being discharged from hospitals. The OIG report concluded that while serious problems in placing Medicare beneficiaries in nursing homes are not apparent, SNFs are changing their admitting practices in response to the new payment system." [GAO Director of Health Financing and Public Health Issues William Scanlon echoed this sentiment stating: "We believe that overall payments to SNFs are adequate. In fact, we and the Department of Health and Human Services Inspector General are concerned that the PPS rates Medicare pays may be too generous."]

- Impact on physician services: The survey results of 1,300 physicians was "very reassuring . . . Among physicians accepting any new patients, over 95 percent were accepting new Medicare fee-for-service patients both in 1997, before the new payment policy changes were implemented, and in early 1999."

These observations can't assure that problems will not materialize. MedPAC cited concerns with hospital outpatient payment rates for small rural hospitals and cancer hospitals, the mismatch between payments and costs for SNF patients "who require relatively high levels of nontherapy ancillary services," and other areas. However, the MedPAC analysis correctly cautions against instituting wholesale or broad policy changes before adequate data is available for a proper evaluation.

Administration is Culpable

Despite this state of flux, the Administration has taken several actions that were not intended by Congress. One critical action is its use of "risk adjustors" (adjustments made to managed care providers to compensate for their patients who are assumed to be healthier than the average Medicare beneficiary). Both Congress and CBO assumed that the risk adjustors would be implemented in a budget-neutral fashion — i.e., shifting savings from one area to another. However, HCFA's implementation has resulted in overall payment reductions and as a result in overall savings reductions. This unintended payment reduction has caused many HMOs to leave Medicare, and so denied many Medicare beneficiaries the choices of health services that Congress intended.

Roughly half a million seniors have suffered reduced choices (407,000) or have had their choices eliminated (51,000) entirely. It is almost impossible to avoid the conclusion that the Administration opposes Medicare+ Choice and is using the risk adjustment system to decrease payments to the managed care plans that seniors deserve to have as an option.

While the managed care risk adjustor issue is perhaps the largest of the unintended consequences of BBA'97, it is not the only one. The BBA directed HCFA to institute prospective payment systems (PPS) for a host of Medicare services — including outpatient hospital services. The outpatient hospital service PPS was supposed to have gone into effect in January of this year, but will not go into effect until the summer of 2000.

While HCFA may have some justification for its difficulties in implementing some of the BBA'97 policy changes (for example, its difficulties in reaching Y2K compliance), the fact remains that their delay furthers the uncertainty on the part of both beneficiaries and providers and inevitably leads to unintended payment consequences.

Less excusable has been HCFA's refusal to implement many administrative reforms that would smooth Medicare operation and conform to Congress' intent. These reforms include virtually the entire gamut of Medicare services — including hospitals, skilled nursing facilities, ambulatory surgical centers, and physician payments. On September 24, Senate Finance Committee Chairman Roth sent a letter to the President that contains a three-page list of administrative adjustments that should be made immediately.

Finally, the Clinton-Gore Administration's evident antagonism towards for-profit nursing homes cannot go unaddressed. At least some of the closings of nursing homes are a direct result of this Administration's actions.

Medicare and the Future

Any conclusion regarding the current Medicare spending conundrum should be prefaced on Medicare's future. First, savings in Medicare spending — whether projected or not — serve to extend the life of the Medicare Trust Fund. That means the savings stay with Medicare — in contrast to the Clinton budget which, as stated by CBO Director Dan Crippen, proposes using $19 billion in Medicare savings "to spend those savings, however, not on Medicare, but on

discretionary, and other mandatory programs." Medicare will need all of these resources in the near future.

Baby boomers will begin entering the system after 2010. CBO projects Medicare's fee-for-service spending will increase from $178 billion in 1998 to $302 billion in 2009. Overall Medicare spending will increase from 2.5 percent of GDP in 1998 to 4.9 percent in 2030 when the last of the baby boomers enter the program.

As a result of these impending pressures, a slowdown in spending growth was intended by the Medicare changes contained in BBA'97. Thus far, not only have these been realized but additional savings as well. Despite the fact that it has been two years since the enactment of BBA'97, it is still too early to state why these savings have materialized. There are a host of possible answers but none definitive — it is likely that the additional slowdown in spending is due to a variety of causes. However, it is imperative that the questions — such as the impact on the sickest nursing home patients — be answered as soon as possible and adjustments be made if warranted.

However, until BBA 1997's changes have been fully implemented — let alone analyzed — it would be premature to make further broad policy changes to a market that is still just now coming to grips with the largest ones since Medicare's inception.

This warning also serves as an implicit indictment of the Clinton-Gore Administration's Medicare policy. The Administration's actions jeopardize Medicare more than anything Congress has done. Its agency in charge of Medicare, HCFA, has been unable to implement the reforms in BBA'97 in a proper or timely fashion, or even to achieve Y2K readiness; and, the White House has refused to address Medicare in a serious policy manner.

Beginning with the undermining of the Bipartisan Medicare Reform Commission earlier this year, and continuing through the President's budget which proposed expanding Medicare benefits and papering over the system's financial imbalance (with a cosmetic improvement to its trust fund balance but without the future real resources to make good the future funding shortfall), the Clinton-Gore Administration's approach has bordered on Medicare malfeasance. This approach continues with its endorsement of an expensive prescription drug benefit outside the context of full reform. It's evident again with its steadfast refusal to implement administrative adjustments to BBA'97. It is folly on the part of this Administration to undercut the prospect of bipartisan reform while at the same time pushing to expand Medicare during this state of flux — and at the same time doing less than nothing to facilitate the implementation of BBA'97.

In short, it is long past time that the Clinton-Gore Administration ceased adding to Medicare's problems and started constructively contributing to some solutions. When dealing with a program as important and politically sensitive as this one is, it is not always easy to separate rhetoric from reality. Yet, policy decisions affecting 39 million Americans must not be clouded by political considerations. The consequences are too great.

Written by Dr. J.T. Young, 224-2946